

**F** Additional Information - Example

Question Number: \_\_\_\_\_ Name of Individual: \_\_\_\_\_

Condition/Diagnosis: \_\_\_\_\_

Treatment Received: \_\_\_\_\_

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: \_\_\_\_\_

Additional tests or treatment recommended? \_\_\_\_\_

Medication Prescribed (if any): \_\_\_\_\_

\_\_\_\_\_ Currently taking medication? ☐ Yes ☐ No

Physician Name \_\_\_\_\_

Phone # (\_\_\_\_\_) \_\_\_\_\_ City &amp; State \_\_\_\_\_